EXHIBIT “1”

William Wallace v. Stanley Mourton and Alton Bean Trucking , Inc AT1298913
Aaron Mutnick to: eric, Chandler 08/09/2016 04:15 PM
Bcc: JKent, BSKuhlmann

Eric and Chandler:

I have reviewed the medical bills and records you have provided for William Wallace .

There is approximately $19,200 in paid or incurred medical bills. This number will likely go up some when the $4,601 Wadley RMC charge from July 26, 2016 is processed by Mr. Wallace's health care provider. I am not including a $6,445 MRI to his shoulder from October 23, 2015 as that appears related to one of his three prior shoulder surgeries. There are a few other unrelated office visits (gout in foot) that *are* included but those are nominal.

I propose a $105,000 (high) and $25,000 (low) settlement agreement and a dismissal with prejudice of Defendant Alton Bean Trucking, Inc. (Mr. Wallace would be releasing Stanley Mourton as well as whatever entity, if any, that Mr. Mourton may be attempting to operate as- we can figure that out later).

The low guarantees that Mr. Wallace can reimburse his health care insurer dollar for dollar without incurring any additional litigation expenses and have additional monies leftover . The high is over five times the paid or incurred amount, and is only that high because you have indicated that Mr. Wallace would only agree to a "six figure" high. If Mr. Wallace believes that an East Texas federal jury will award a total verdict more than five times the paid or incurred medical expenses (especially in light of the medical records I have excerpted below) then please give me a call to discuss the basis for that position. Finally, the dismissal of prejudice also guarantees that Shelter and Mr. Wallace won't have to litigate any declaratory judgment actions.

I understand that a narrative is forthcoming from Dr. Moore. I suspect that Dr. Moore will opine that this accident caused an acetabular labral tear at the right hip which will necessitate right hip arthroscopy . Based on the medical records that I have excerpted below I don't need to see that narrative. These records below also highlight why the $25,000 low end of the settlement agreement is more than generous.

After you have had a chance to review and visit with Mr. Wallace please give me a call or send me an email to let me know your response to this proposal.

Records Review

- An MRI of Mr. Wallace's pelvis on June 3, 2015 showed femoroacetabular impingement and left hip early degenerative joint disease. Both degenerative conditions. Because there was no objective finding to support Mr. Wallace's injury Dr. Kahn referred Mr. Wallace to Dr. Moore because he is "an othro that does mva cases due to the mri results of pelvis."

DIAGNOSTIC IMAGING AND WORKUP: MRI OF PELVIS DONE ON 6/3/15 AT HCE SHOWS FEMOROACETABULAR INPINGEMENT BILATERALLY AND LEFT HIP EARLY DJD

REFERRAL: WILL REFER TO AN OTRHO THAT DOES MVA CASES DUE TO MRI RESULTS OF PELVIS

COMPLIANCE TESTING: I looked at the Texas/Arkansas prescription monitoring program and they did not have multiple opioid prescribers. Today a Urine drug screen was obtained.

FOLLOW UP: AS NEEDED

The above listed assessment and treatment plan was extensively discussed with the patient today to the patient's satisfaction. All questions were answered. The patient demonstrated verbal understanding of the treatment plan.

Patient seen in conjunction with Dr. Khan who agrees with the aforementioned history, exam, assessment and plan.

Sincerely,

BREANN HORNER FNP
Mohammed Khan, M.D.
Board Certified Pain Medicine
Board Certified Physical Medicine and Rehabilitation.

Electronically signed by Dr Mohammed Khan MD 06/11/2015 01:10 pm

- Dr. Moore then saw Mr. Wallace a few weeks later on June 29, 2015, 10 months after the accident, and likewise identified degenerative conditions as the only cause of his pain . He did not opine at that time that Mr. Wallace's pain was caused by an acetabular labral tear at the right hip .

Page 2
William Wallace, #1800637, DOB: 09/25/1975
June 29, 2015

Musculoskeletal: (continued)
He has 5/5 muscle strength in all myotomes. His lumbar paraspinal musculature has some mild tenderness to palpation. He does have tender points nonspecifically throughout the buttock as well as around the lumbar spine. There is pain with range of motion in the lumbar spine.

Hips: The hips are examined in detail as well. He has no instability. He has pain with internal rotation and adduction. There is positive flexion-adduction-internal rotation test, negative flexion-abduction-external rotation, and tenderness to palpation over the groin. He has no instability noted.

Neurologic Exam: He has 5/5 muscle strength in all myotomes and 2+/4 reflexes bilaterally in upper and lower musculoskeletal. He has intact sensibility.

Osteopathic Exam: The cervical, thoracic, lumbar, and lumbosacral spine are all examined in multiple positions and found to be free of somatic dysfunctions.

X-RAYS: AP pelvis was appropriately ordered, done, and interpreted by Samuel Moore, D.O. in the office as follows: No acute bony abnormality.

MRI, PELVIS (without contrast, 06/03/15): Femoroacetabular impingement bilaterally is seen, worse on the left than the right, with some early hip degenerative joint disease. No other bony or soft tissue abnormalities are noted.

IMPRESSION:
1. Femoroacetabular impingement, bilateral hips.
2. Synovitis, bilateral hips.
3. Myofascial strain, lumbar spine.

- After Mr. Wallace's first visit to Dr. Moore, Mr. Wallace tells Dr. Rosenzweig in August 2015 that he plays softball.

KENNETH M. ROSENZWEIG, MD

Psychiatric- Negative for depression, difficulty sleeping or nervousness.
Endocrine- Negative for change in hat or ring size, excessive thirst, or excessive urination.
Hematologic/Lymphatic- Negative for bleeding tendency or enlarged lymph nodes.
Allergic/Immunologic- Negative for latex allergy, metal allergy, or topical iodine alle

PAST MEDICAL HISTORY:
Asthma.

PAST SURGICAL HISTORY:
Tonsillectomy, shoulder surgery x 3, oral surgery x 4.

FAMILY HISTORY:
Diabetes, heart disease.

SOCIAL HISTORY:
He is Caucasian, right-hand-dominant male who works in the financial business for Aegon. has been with this current employer for 10 months. His job is in sales and is not considered physical demanding. He is married and lives with his wife and children. He participates in softball. He reports that his problems started after the motor vehicle accident. He has been treated by Dr. Khan in Texarkana as well as Dr. Moore. He feels like his injury may have be hip impingement and rotation of the pelvis with the SI joint pain. He does have an attorney regarding the motor vehicle accident. He has had physical therapy which did not help. He h

- Mr. Wallace then develops a small disc protrusion at L5-S1 after he has been playing softball. This protrusion did not exist immediately after the accident. You can see this by comparing the MRI of the lumbar spine on October 2, 2014 which showed "no evidence of traumatic injury, disc protrusion, or spinal stenosis" with the MRI from November 13, 2015 which shows the small protrusion along with degenerative changes.

IMPRESSION: The lumbar spine shows no evidence of acute traumatic injury, disc protrusion, or spinal canal stenosis. Mild facet hypertrophy is seen at the L4-5 and L5-S1 levels.

Electronically Signed by

Michael L. Hill, M. D.

DD: 10/02/2014/DT: 10/02/2014

NAME: WALLACE, WILLIAM **DATE OF EXAM: 11/13/2015**
DOB: 09/25/1975 Patient No: 58075
Physician: Rosenzweig, Kenneth

MRI lumbar spine

History: Low back pain

Technique: Sagittal and axial T1, sagittal and axial T2, sagittal inversion recovery

Findings: Images are interpreted using the last freely mobile segment at the L5 low. There is no fractu spondylolisthesis. Disc height is maintained. The conus terminates at the L1 level. Incidentally noted a sacral perineural cysts.

L1-2: Unremarkable

L2-3: Unremarkable.

L3-4: Unremarkable.

L4-5: Unremarkable.

L5-S1: There is a small right paracentral disc protrusion measuring 2 mm anterior to posterior. This anterior thecal sac without significant stenosis.

Impression: Small L5-S1 disc protrusion. Otherwise normal.

- Mr. Wallace's other treating physician Dr. Rosenzweig repeatedly found "no objective findings on any of his diagnostics" and repeatedly admonished Mr. Wallace on drug use:

[redacted] SPINE SPORTS
KENNETH M. ROSENZWEIG, MD

EXAMINATION:
He is well developed and well nourished with multiple tattoos. He is 6 feet 3 inches tall and weighs 258 pounds. Blood pressure is 113/77. Pulse is 72. He rates his pain as a 6/10. He presents with his family. He is tender to palpation over the SI joint on the right hand side and greater trochanter of the hip more on the right than the left. Reflexes are brisk and symmetric in the knee and ankle. He has no root tension findings with a negative FABER maneuver. He is palpably tender at the SI joint and is tender over the PSIS on the right hand side. Pulses are intact. Hair distribution is normal. He has good lumbar flexibility in forward flexion, deflexion, and rotation.

STUDIES REVIEWED:
The MRI of the pelvis reveals a right inguinal hernia, femoral acetabular impingement bilaterally more pronounced on the left, and early degenerative joint disease of the left hip.

The MRI of the spine performed in October of 2014 by report reveals no evidence of acute traumatic injury, disk protrusion, or spinal canal stenosis. There is mild facet disease at L4-L5 and L5-S1.

IMPRESSION:
Mechanical strain, one year out from a rear end collision while restrained.

PLAN/RECOMMENDATIONS:
Diagnostics have not been revealing of a source of pain. Treatment to date has not been successful. His examination is consistent with SI joint discomfort with some enthesopathy at the PSIS.

KENNETH M. ROSENZWEIG, MD

PATIENT NAME: William Wallace
DATE: September 22, 2015
DOB: September 25, 1975

HISTORY OF PRESENT ILLNESS:

Mr. Wallace returns for follow-up. He is a 39-year-old gentleman involved in a motor vehicle accident in August of 2014. He underwent SI joint injections bilaterally with PSIS trigger point injections on September 9. He states that he had some relief the day after the injection. It lasted approximately three days. The pain now is "worse" than it was prior to the injection. He is having to take a lot of time off work due to pain. He feels like his pain is getting worse with each injection. He states that he has been on OxyContin with his local physician. On further discussion, he has had previous radiofrequency in this area. It did not help before. This injection did not help this time. Meanwhile, he continues to complain bitterly of back and buttock pain. He remembers the injury being a hard jolt. He did not tolerate the gabapentin very well. He feels like he is no better with the medications. He is adamant about how bad he is hurting. At this point in time after the motor vehicle accident, the objective studies have not correlated with his pain complaints. Treatment based on where he is tender has not been successful.

We discussed the facet joints where the MRI showed degenerative changes. They are very close to the SI joint and may be contributing to his pain. I do not recommend repeating the SI joint injection.

PLAN/RECOMMENDATIONS:

1. An updated MRI will be obtained to see if he develops new pathology that correlates with the physical exam today.
2. Cymbalta was prescribed to manage his chronic pain.
3. He was given a refill of hydrocodone without the intent to continue this long term. We need objective findings to clarify his pain complaints and justify his need for ongoing narcotic management. He has taken this into advisement and is understanding of the risk of continued narcotic use. It is not the intent of this office to do chronic pain, but we do treat people in pain. He has expressed understanding.
4. The patient will return to the clinic for follow-up after the MRI has been performed.

Kenneth M. Rosenzweig, M.D.

EXAMINATION:

He is 6 feet 3 inches tall and weighs approximately 256 pounds. Blood pressure is 124/88. Puls is 91. He rates his pain as a 3/10 to 4/10. He presents with his family. Reflexes re intact in the knee and ankle. He has positive Lasègue's maneuver on the left but does not flip. He has complaints of back and buttock pain with straight-leg-raising. He complains of pain in his buttock with the FABER maneuver on the right. He moves easily with no antalgia and not moto deficits.

IMPRESSION:

Continued back pain with the MRI revealing a small disk protrusion that was not present before. It is noncompressive.

PLAN/RECOMMENDATIONS:

1. It is possible he could have diskogenic pain which would require diskography for evaluation. He has had this in the past. He is not tolerating the Cymbalta for pain management.
2. He is requesting a refill of hydrocodone which was provided with reluctance.
3. Lab work will be obtained to identify any connective tissue disorder that may be contributing to his pain complaints.

ORTHOPAEDIC SPINE & SPORTS
KENNETH M. ROSENZWEIG, MD

PATIENT NAME: William Wallace
DATE: January 15, 2016
DOB: September 25, 1975

HISTORY OF PRESENT ILLNESS:
Mr. Wallace returns for follow-up from Texarkana. He is having ongoing issues with chronic back and buttock pain. He states that he had a gout flare two weeks ago. He was treated by a local physician with Indocin, Tylenol 3, and some shot. This occurred after he went hiking with his family. Ever since then, his pain has not been as bad since he had his gout flare. He stopped Cymbalta because of the cost. It was not covered by insurance. It was not making him feel any better. He found that tramadol was helping his pain. He claims he stopped the hydrocodone. I had advised him that it was not in his best interest to continue hydrocodone particularly if we did not have any objective findings on any of his diagnostics.

ORTHOPAEDIC SPINE & SPORTS
KENNETH M. ROSENZWEIG, MD

PLAN/RECOMMENDATIONS:

When discussing his prior treatment, he had extensive treatment in Texarkana before he sought care here in Little Rock. He had radiofrequency performed in Texarkana. He remembers this being the point in time when his pain became significantly worse. There has been no help with any intervention. Therefore, he is not a candidate for further injections. He has had an MRI of the pelvis and lumbar spine which does not reconcile his pain complaints.

We discussed a bone scan to identify any physiology or activity that would account for his pain in the location of the back and buttock. The anterior acetabular impingement is unlikely the source of posterior buttock and back pain. It is good that Mr. Wallace has been able to get off his hydrocodone. He is now taking tramadol for his pain. We still need to identify a source of pain. Therefore, a bone scan with total body imaging is recommended. We will see him back after this study has been performed.

- Dr. Moore's revised finding on July 12, 2016- that Mr. Wallace has an an acetabular labral tear at the right hip- is not based on any new objective tests; it is after this lawsuit was filed; and, more importantly, does not attribute the tear to an acute injury. Dr. Moore could have related the tear to this accident in 2015 or after this lawsuit was filed in 2016 but refused to do so.

- Mr. Wallace acknowledges in his medical records that the impact was at low speeds less than 10 mph.

Patient: WILLIAM WALLACE (ID# 175978) Date of Birth: 09/25/1975
Visit on 9/5/2014 (Log# 20290283)

History of Present Illness:
Patient came in for a follow-up of pain in the neck and lower back which was originally seen on 8/25/2014. Original onset was Sun, Aug 24, 2014 at 4:30 PM. The patient describes the severity as 6/10, with 10 being the worst imaginable. The problem is made better by medication and made worse by movement.

Context - Initial History: The patient reports it was the result of an injury, which had a sudden onset. The patient had no similar problems in the past. This was caused by a motor vehicle accident. Patient was sitting in front passenger seat. Vehicle was traveling less than 10 MPH. Site of impact was rear bumper. Vehicle collided with another vehicle. semi-truck. Medium force collision. Direct impact collision. Patient was wearing a combined lap/shoulder belt. Patient ambulated at the scene of the accident. The patient reports that it is associated with low back pain, neck pain Patient in MVA on 8/24/14. C/O cervical pain and lower lumbar pain. Describes pain as "achy". Denies loss of bowel or bladder control. Denies any numbness or tingling in all four extremities.

- Mr. Wallace's ailments are likely compounded by his pre-existing BMI of 34.
  - Tobacco Use: denies

Family History: patient specifies "No medical problems"
Vitals:
Vital signs obtained 10/08/2014 9:15 AM
Temperature: 98.2 °F (Oral), Pulse: 71 BPM, **BP: 136/92**, Respirations: 20/min, O2 saturation: 98%, O2 Delivery: RA, Weight: 272 LBS, Height/Length: 6' 3", **BMI: 34.0**, **Pain: 7 per 0-10 pain intensity scale.**
First entered 10/08/2014 09:25 by Kessell, Carlen

Sincerely,

Aaron M. Mutnick
Litigation Attorney
Shelter Insurance
573-214-4163 (office)